Primary Care: Its Essential Role in Value-Based Health Care

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Problem

- The U.S. spends more on health care than any other industrialized country.

- Americans as a group have poorer health outcomes than many nations that devote fewer resources to health care.
Healthcare Expenditures vs. Outcomes

Healthcare Expenditures as % of GDP, 2005*

Average life expectancy, 2007

*McGinnis JM, Russo PG, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(2):78–93
Solution: More Primary Care

• Primary Care improves quality of care
• Primary Care lowers the total cost of care
“Robust evidence shows that patient care delivered with a primary care orientation is associated with more effective, equitable, and efficient health services. **Countries more oriented to primary care have residents in better health at lower costs. Health is better in U.S. regions that have more primary care physicians,** whereas several aspects of health are worse in areas with the greatest supply of specialists. People report better health when their regular source of care performs primary care functions well. In addition to features promoting effectiveness and efficiency, **there are fewer disparities in health across population subgroups in primary care–oriented health systems.**”

Barbara Starfield, M.D., M.P.H.
U.S. HEALTHCARE WASTE = NETHERLANDS GDP

- $210bn: Unnecessary Services
- $130bn: Inefficient Delivery of Care
- $55bn: Prevention Failures
- $105bn: Inflated Prices
- $75bn: Fraud
- $190bn: Administrative Costs

Total: $765bn in wasted spending

Source: Institute of Medicine (2009 data); The World Bank (2009 data)
Pay Now … Or Pay Later

- Hospital inpatient: 27%
- Hospital outpatient visits/other: 28%
- Professional procedures (non-hospital): 30%
- Drugs: 16%
- Primary Care: 6%
Pay Now … or Pay Later

- Primary Care: 6%
- Care without improved outcomes: 20%
- Rest of health care: 74%
Innovative Payment and Delivery Models

1. Patient-Centered Medical Home
2. Comprehensive Primary Care (and +)
3. Independence at Home
4. Other Programs/Initiatives
Joint Principles of the Patient Centered Medical Home (PCMH)

- Personal Physician
- Physician-Directed Medical Practice
- Whole-Person Orientation
- Care Coordinated Across Settings / Community
- Quality and Safety
- Enhanced Access
- Payment
MACRA Evolves Medical Home Criteria

• A Medical Home Model as defined under MACRA is required to have the following elements:
  • A primary care focus consisting of primary care or multispecialty practices with primary care physicians and practitioners that offer primary care services.
  • Empanelment of each patient to a primary clinician.
Medical Home Criteria

• A Medical Home Model also must have at least four of the following additional elements:
  • Planned coordination of chronic and preventive care
  • Patient access and continuity of care
  • Risk-stratified care management
  • Coordination of care across the medical neighborhood
  • Patient and caregiver engagement
  • Shared decision-making
  • Payment arrangements, in addition to, or substituting for fee-for-service payments (for example, shared savings, population-based payments)
Comprehensive Primary Care (CPC)

- Another PCMH model launched by CMS in 2012
- Multi-payer model
- 500 practices in 7 regions
- 5 care delivery functions
CPC’s 5 Care Delivery Functions

1. Care Management
2. Access and Continuity
3. Planned Care for Population Health
4. Patient and Family Caregiver Engagement
5. Comprehensiveness and Coordination
CPC Payment Model

1. Fee-for-Service Payment
2. Risk-adjusted PMPM Care Management Fee
3. Performance-Based Payment
CPC+

- CMS launched next generation of CPC in 2017
- Track 1 (Jan. 2017): 2,983 practices in 14 regions
- Track 2 (Jan. 2018): practices will be announced later this year
Comprehensive Primary Care Plus (CPC+)
A new model for primary care in America

CPC+ Participating Regions & Provisional Payer Partners

- North Hudson-Capitol Region
- Greater Philadelphia Region
- Ohio & Northern Kentucky Region
- Greater Kansas City Region

- Region spans the entire state
- Region comprises contiguous counties
Independence at Home

• Congressionally-designed demonstration
• CMS launched in June 2012
• 15 primary-care practices
• 10,000 chronically-ill Medicare beneficiaries
• Selected practices provide home-based primary care
Independence at Home Results

• CMS reports $746 savings per beneficiary in most recent program year, which more than offset the incentive payments.

• Practices are meeting performance thresholds for the required quality measures
  – all-cause hospital readmissions within 30 days
  – medicine reconciliation in the home within 48 hours of hospital discharge or ED visit
  – Etc.
Other Programs/Initiatives

• Payment for Chronic Care Management Services
  – Medicare Part B established in 2015 and 2017
  – Monthly basis; Patient must affirmatively sign up

• Diabetes Prevention Program
  – “Structured lifestyle intervention” that includes dietary coaching, lifestyle intervention, and moderate physical activity
  – 12-month program -- 16 core sessions in a classroom setting (CDC approved curriculum), with monthly follow-up sessions
Issues to Watch

• When will CMS scale up the CPC and CPC+ programs?
• When will CMS (or Congress) scale up the Independence at Home program?
• Which models will the PTAC approve for CMMI to evaluate and test?